DEPARTMENT FOR MEDICAID SERVICES
MODEL WAIVER II SERVICES MANUAL

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care and Community Alternatives
275 East Main Street 6W-B
Frankfort, KY 40621

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SECTION I – INTRODUCTION

A. INTRODUCTION

This Model Waiver II Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of claims for services provided to qualified recipients of Medicaid.

This manual shall provide basic information concerning coverage and policy. It shall assist you in understanding what procedures are reimbursable, and shall also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 3.6 might be replaced by new pages 3.6 and 3.7).

Precise adherence to policy shall be imperative. In order that claims may be processed quickly and efficiently, it shall be extremely important that you follow the policies as described in this manual. Questions concerning the application or interpretation of agency policy should be directed to the

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care
275 East Main St, 6W-B
Frankfort, Kentucky 40621
Phone: (502) 564- 5560.

B. FISCAL AGENT

The Kentucky Department for Medicaid Services (DMS) employs a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION I – INTRODUCTION

GENERAL INFORMATION

Both Federal and State statutes and regulations governing the administration of the State Plan shall bind DMS. The federal government shall not reimburse the state for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky DMS may request a return of any monies improperly paid to providers for non-covered services.

The Kentucky Medicaid Program services eligible recipients of all ages. DMS coverage and limitations of covered health care services specific to the Model Waiver II program shall be specified in the body of this manual in Sections IV, V, VI.VII and VIII. However, policy outlined in the Kentucky Administrative Regulations, Title 907, Chapter 1, Section 595 shall supersede information contained in this manual.

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SECTION II - KENTUCKY MEDICAID PROGRAM

A. GENERAL

The Kentucky Medicaid Program, frequently referred to as the Medicaid Program, shall be administered by the Cabinet for Health and Family Services (CHFS), Department for Medicaid Services (DMS). The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the Health Care Financing Administration.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program shall be to aid the medically indigent of Kentucky in obtaining quality medical care.

DMS is bound by both Federal and State statutes and regulations governing the administration of the State Plan. DMS shall not reimburse for any services not covered by the plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid Program, Title XIX, Medicaid, shall not be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons sixty-five (65) years of age and older, and some disabled persons under that age. The Kentucky Medicaid Program serves eligible recipients of all ages.

B. ADMINISTRATIVE STRUCTURE

DMS, within CHFS shall bear the responsibility for developing, maintaining, and administering the policies and procedures, scope of benefits, and basis for reimbursement for the medical care aspects of the Program. DMS makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits, which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits shall be the responsibility of the local Department for Community Based Services (DCBS)/Family Support offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program shall be guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council shall be composed of eighteen (18) members, including the Secretary of the Cabinet for Health Services, who serves as an ex officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members shall be lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months or as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes shall make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees shall be decided by the professional organization that the technical advisory committee represents. The technical advisory committee provides for a broad professional representation to the Advisory Council.

As necessary, the Advisory council shall appoint sub-committees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program shall be to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulate that the Title XIX Program shall be payer of last resort for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement for such third party groups for medical services provided. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount shall be made to Medicaid, as the amount

payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid covered services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid program. From those professionals who have chosen to participate, the recipient shall select the one from whom he wishes to receive his medical care.

If the Department makes payment for a covered service and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and a bill for the same service shall not be tendered to the recipient, and payment for the same service shall not be accepted from the recipient.

Providers of medical services or authorized representatives shall attest, by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine or imprisonment, or both.

The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements set forth in KRS 369.101 to 368.120, and all applicable state and federal statutes and regulations.

A home health provider choosing to utilize electronic signatures shall:

(a) Develop and implement a written policy which shall:
1. Be adhered to by all of the provider's employee's, officers, agents, and contractors;
2. Stipulate which individuals have access to which electronic signature(s) and password authorization; and

3. Ensure electronic signature(s) are created, transmitted, and stored in a secure fashion.

(b) Develop a consent form which shall:
1. Be completed and executed by each individual utilizing an electronic signature;
2. Attest to the signature's authenticity; and
3. Include a statement indicating the individual has been notified of his or her responsibility in allowing the use of the electronic signature.

A home health provider shall produce to the Department a copy of the agency's electronic signature policy, the signed consent form and the original filed signature immediately upon request.

All claims and substantiating records shall be auditable by both the Government of the United States and the Commonwealth of Kentucky.

The recipient's *KyHealth Choices* card should be carefully examined by the provider to see that the recipient's name and ten (10) digit member identification number appear on the card. If there is any doubt about the identity of the recipient, the provider may request a second form of identification. A provider cannot be paid (reimbursed) for services rendered to an ineligible person. Failure to validate the identity and eligibility of an individual prior to a service being rendered may result in being out of compliance with KAR 1:671. Any claims paid by DMS on behalf of an ineligible person may be re-couped from the provider.

Eligibility and benefit information is available to providers via the following:
1. Voice Response Eligibility Verification (VREV) available 24 hours/7 days a week at (800) 807-1301;
2. KYHealth-Net at http://chfs.ky.gov/dms/kyhealth.htm; and
3. Call Center Customer Representative at (800) 635-2570.

NOTE: To access KyHealth-Net, you must have a single sign on account. If you do not have an account, contact the EDI helpdesk at (800) 205-4696 or send inquiries via email to KY_EDI_Helpdesk@eds.com.

Information contained on the KYHealth-Net is highly confidential and access should be strictly limited to those with valid reasons. It is the responsibility of the provider and the system administrator to ensure all persons with access understand the appropriate use of this data. DMS highly recommends the

creation and implementation of guidelines within your office outlining appropriate and inappropriate uses of this data.

The provider's adherence to the application of policies in this manual shall be monitored through post-payment review of claims by the Department, or computer audits or edits of claims. If computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to post-payment review by the Department.

All claims and payments shall be subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be entitled to the same level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program shall be entitled to the same level of confidentiality afforded patients not eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services shall be reviewed for recipient and provider abuse. Willful abuse by the provider may result in suspension from Program participation. Abuse by the recipient may result in placement of the recipient into a managed care program or a restricted program such as Lock-In Program.

Claims shall not be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, claims shall not be paid for services that required and were not granted, Prior Authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672 and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. Providers shall notify recipients in advance of the recipient's liability for any charges for non-medically necessary AND non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the

Department and a claim for the same service shall not be paid by the Department.

E. Public Law 92-603 (As Amended)

Section 1909. (a) whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title;
(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,
(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or
(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit or such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, of suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or
(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and
(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.
(C) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home

health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(D) Whoever knowingly and willfully—

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rated established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) As a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Appeal Process for Refund Requests

Inappropriate overpayments to providers that are identified in the post payment review of claims shall result in a refund request. If a refund request occurs subsequent to a post payment review by DMS or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care and Community Alternatives
275 East Main Street, 6 W-B
Frankfort, KY 40621

If the provider has filed no response (refund or appeal) with Medicaid within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from any future payment(s).

G. Timely Submission of Claims

According to federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45 (d) (5) as follows, "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be considered for payment if more than twelve (12) months have elapsed between EACH RECEIPT of the aged claim by the program.

Claims should be submitted to:

EDS
P.O. Box 2106
Frankfort, KY 40601

Providers may contact EDS at the following telephone numbers:
EDS Member Management at (502) 426-4888 or (800) 292-2392.

Providers may contact EDS at the following FAX numbers:
(800) 807-7840, (800) 807-8843, or (502) 429-5233

H. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system, which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services.

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from the KenPAC program.

I. Human Service Transportation Delivery (HSTD) Program

The Human Service Transportation Delivery (HSTD) Program provides non-emergency, non-ambulance medical transportation services to eligible Medicaid,

Vocational Rehabilitation and Department of the Blind recipients. It also combines the resources of public and private transportation providers in an efficient, cost effective and easily accessible transportation program throughout the Commonwealth of Kentucky.

The Department for Medicaid Services (DMS) contracts with the Kentucky Transportation Cabinet (KyTC) to manage the daily operation of the HSTD program. The Office of Transportation Delivery (OTD) within the KyTC answers complaints from recipients, subcontractors, or regional brokers and resolves them.

if you need assistance with any issues or concerns, contact (888) 941-7433. Under the HSTD program, the Commonwealth is divided into 15 transportation regions. A regional broker coordinates transportation services for each region through use of a network of providers located within the region.

J Lock-In Program

DMS shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. DMS shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the service of these assigned providers, except in cases of emergency services and appropriate referrals by the physician case manager. In addition, provider and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the Lock-In Program, unless the appropriate case manager has pre-approved a referral, or for emergency services.

K. Early and Periodic Screening, Diagnosis and Treatment (EPDST) Program

Under the EPSDT Program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21st) year may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide screenings at specified time intervals

according to age (termed a periodicity schedule) to identify potential physical and mental health examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services and treatments, even if Kentucky Medicaid does not normally cover the service or treatment. However, the service or treatment must be listed in 42 USC Section 1396-d (a), which defines what services can be covered by state Medicaid programs. More information regarding the EPSDT Program can be obtained by calling the EPSDT Program within DMS.

L Kentucky Health Care Partnership Program (Passport)

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a capitation managed care system for physical health services to persons residing in Region 3 (Shelby, Spencer, Trimble, Washington, Marion, Meade, Nelson, Oldham, Henry, Jefferson, LaRue, Breckinridge, Bullitt, Carroll, Hardin and Grayson counties).

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in a capitation managed care system. These recipients receive services through the traditional Medicaid Program.

M HIPAA (Health Insurance Portability and Accountability Act of 1996)

CHFS is required to maintain the privacy of personal health information and must give the Medicaid recipient a notice that describes our legal duties and privacy practices with regard to personal health information. In general, when health information is released, we must release only the information needed to achieve the purpose of the use or disclosure. However, with few exceptions, all personal health information will be available for release if the recipient signs an authorization form to authorize the release of the information, or due to a legal requirement.

III. MODEL WAIVER II SERVICES PROGRAM

A. Waivers Requested

The Department for Medicaid Services(DMS), Cabinet for Health and Family Services (CHFS) requested that the Secretary of the Department of Health and Human Services (HHS) exercise his authority under section 1915 (c) of the Social Security Act to grant a waiver to the Department that would permit Title XIX coverage under the State Plan for services that may be required by the Medicaid Program recipient who would otherwise require the Nursing Facility (NF) level of care in a hospital based nursing facility (NF) that accepts ventilator dependent patients. The cost of institutional care could be reimbursed under the Kentucky Title XIX (Medicaid) State Plan. A waiver was requested of Section 1902 (a)(10)(B) and (c)(i)(III) of the Social Security Act which addresses amount, duration and scope of services. This array of services provided in accordance with a properly established individualized plan of care in accordance with the physician's order shall include the following:

1. Nursing Services (Registered Nurse or Licensed Practical Nurse)
2. Respiratory Therapy Services

B. Target Population

1. Demographics of Target Population

The target group for Model Waiver II services shall be for persons who are ventilator dependent twelve (12) or more hours daily and who may, without these services, be admitted to a hospital-based NF for which the cost could be reimbursed under the existing State plan. The individual shall be given the choice of institutional care or waiver services. Model Waiver II shall be available to persons of any age. Anyone who is an eligible Medicaid recipient and meets the waiver service eligibility requirements may receive these benefits.

The eligibility groups include the mandatory categorically needy, optional categorically needy including individuals under a special income level, and the medically needy.

The level of care provided in a NF and covered under the Medicaid Program shall be defined in Federal Regulations 42 CFR 440.40 and 440.150, respectively. Nursing facility regulations are contained in 907 KAR 1:022. Medicaid recipients and potential Medicaid recipients shall be advised of the availability of the Model Waiver services option. Medicaid recipients who are currently hospitalized or residing in a

hospital-based NF shall be eligible to receive the Model Waiver services upon discharge to avoid re-institutionalization. Medicaid recipients who are currently residing at home shall be eligible to receive Model Waiver services to avoid institutionalization in a NF.

The State reserves the right to exclude from this program those individuals for whom there is a reasonable expectation that Model Waiver services would be more expensive on an overall basis than the appropriate level of institutional services. Recipients who are inpatients of a hospital, NF, or intermediate care facility for the mentally retarded and developmentally disabled (ICF/MR/DD) or enrolled in a Medicaid-covered Hospice Program shall be excluded.

2. Treatment of Income and Resources of Target Population

Persons expected to be serviced under this waiver shall be categorically needy, eligible under this special income level group as specified in 42 CFR 435.217, or medically needy.

The financial eligibility determinations for the special income provision shall be made in the same manner as determinations are made for NF or ICF/MR/DD.

Institutional deeming rules shall be applied to Model Waiver recipients. Waiver recipients shall be allowed to retain from their own income for their basic maintenance needs an amount equal to the Supplemental Security Income (SSI) basic benefit rate plus the SSI general disregard. This allowable maintenance amount shall change if the SSI benefit rate or standard deduction changes. The recipient liability for the month of admission to the waiver, however, would usually be zero (0) with the following exception:

> Community deeming rules for Medicaid eligibility shall be used for the month of admission for all Model Waiver recipients who are either married or under the age of eighteen (18). This means that the income and resources of the spouse or parent shall be considered to be available for the month of admission only. For the second month and each succeeding month of Model Waiver participation, only the income and resources of the Model Waiver recipient shall be used to determine Medicaid eligibility.

If an individual is being considered for eligibility based upon the special income criteria, the Model Waiver Provider shall follow the usual procedures for admission to the Model Waiver Program. Additionally,

the Provider shall indicate "Pending Special Income" in red ink, if possible, on the material submitted to DMS, or a contractor acting on behalf of DMS. This shall assist in expediting the approval process.

The recipient and family or responsible party shall be advised of the necessity for making an application at the Department for Community Based Services (DCBS) office in their county of residence, in order to ensure service coverage. They shall indicate that they are applying for eligibility under the special income category of the Model Waiver Program as there are other programs which also have a special income category.

NOTE: The recipient and family or responsible party shall be advised of the importance of contacting the DCBS local office within ten (10) days of changes in the following situations:

a. The recipient's Medicaid eligibility was based upon a recent nursing home stay.
b. The recipient's Medicaid eligibility was based upon the "spend-down" category of eligibility.
c. The recipient's Medicaid eligibility was based upon SSI eligibility.
d. Whenever there is a change in the recipient's circumstance(s).

The recipient shall notify the DCBS local office of admission to the Model Waiver Program in order to determine if further applications for Medicaid eligibility under the special income provision of the Model Waiver Project shall be required.

3. Recipient's Continuing Income Liability

If it is determined by DCBS that a recipient has a continuing income liability, this amount shall be paid to the Model Waiver provider by the recipient or responsible party and shall be deducted monthly from the Title XIX Model Waiver payments to the provider. Notification of the amount of the continuing income liability shall be forwarded to the Model Waiver provider from the Department for Medicaid Services on MAP 552. It shall be the responsibility of the provider to collect this money from the recipient.

NOTE: The provider may not collect more than the actual amount of the service provided during the month by the agency.

4. General Outline of Waiver Eligibility Determination

Eligible recipients and Medicaid applicants shall be informed of the available alternatives of care and given a choice with regard to obtaining services in their home or in a NF as well as a choice as to the provider of service. The MAP-350 form is utilized to document choice was given to the individual. A Model Waiver II (MWII) provider shall require the recipient to sign a MAP-350 form at the time of application or reapplication and each recertification.

As part of the qualifying criteria for Model Waiver services, an individual shall meet the level of care criteria for NF placement and require institutionalization in the near future if the requested Model Waiver services are not provided. The recipient's attending physician shall recommend MWII services and certify that without this waiver service the recipient would qualify to be admitted, by a physician's order, to a hospital-based nursing facility.

If NF services are necessary and the recipient chooses to consider the Model Waiver option, a referral shall be made to the Model Waiver provider of the recipient's choice. It shall be recognized that there may be situations in which the recipient and family shall not wish to consider the Model Waiver services alternative or Model Waiver services would clearly not be an alternative for consideration. The Model Waiver provider may receive referrals from any source, including the recipient and his family. Prior to the level of care determination and subsequent assessment and care planning process, the attending physician shall be contacted to obtain his orders regarding the provision of Model Waiver services for the recipient and verification of ventilator dependency of the recipient twelve (12) or more hours daily. A level of care determination for all recipients who wish to consider the Model Waiver alternative shall be performed by Kentucky's approved Quality Improvement Organization (QIO).

The Model Waiver provider shall be responsible for gathering the information as requested by the QIO. The QIO shall make the level of care determination for those recipients wishing to consider the Model Waiver service option. A recent hospital discharge summary, physician's report of a history and physical examination, or possibly a recent Home Health Assessment along with the physician orders, may provide the information needed.

Upon completion of the assessment and care planning process, the Model Waiver provider shall be required to discuss with the recipient and family the options available to them. At this time, if it appears that the recipient shall be eligible to receive services under the waiver, the recipient or his legal representative shall again be asked to make a choice of whether or not to receive Model Waiver services as an alternative to institutionalization. The recipient shall also be asked to certify that he has been advised of the availability of financial planning through DCBS.

For all those recipients who do not wish to consider the Model Waiver services option, but instead wish to obtain NF services, the QIO shall make the level of care determination in the usual manner in accordance with 42 CFR 440.40 and 440.150, respectively.

Hospitals are requested to refer all recipients whose care needs indicate that hospital-based NF services may be required to a Model Waiver provider for information regarding the Model Waiver. It shall be the NF's responsibility to ensure that all recipients shall be informed of the availability of Model Waiver services as an alternative to institutionalization, prior to admission to the NF.

A MWII provider shall notify the local DCBS office and the QIO on a MAP-24 form if a recipient is terminated from the MWII program, or if the recipient is admitted for less than sixty (60) consecutive days to a NF and is returning to the MWII program. A MWII recipient who remains in a NF longer than sixty (60) consecutive days shall be terminated from the MWII program. If the recipient requests readmission to the MWII program after sixty (60) consecutive days, all procedures for a new admission shall be followed.

For detailed information regarding completion of necessary forms, **see Section V, Program Coverage**.

In accordance with Section 1902 (a)(3) of the Social Security Act, and the administrative hearing process described in 42 CFR part 431, Subpart E, individuals who have been denied benefits or who have not been given the choice of Model Waiver services as an alternative to NF services shall be granted an opportunity for a fair hearing, in accordance with 907 KAR 1:563 and 907 KAR 1:022.

SECTION IV –CONDITIONS OF PARTICIPATION

IV. CONDITIONS OF PARTICIPATION

A. Definition of Agency

To participate in the Model Waiver Program, the provider shall be a state licensed home health agency certified for Kentucky Medicaid participation per 902 KAR 20:081. The Division of Licensing and Regulation, Office of the Inspector General, Cabinet for Health Services (CHFS), shall have responsibility for the enforcement of these regulations.

"Home Health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which is licensed as a home health agency by the Kentucky Health Facilities and Health Services Certificate of Need and Licensure Board and is certified to participate as a home health agency under Title XVIII of the Social Security Act.

B. Application for Participation

In order to participate in the Model Waiver Program, the Model Waiver Agency shall complete an application to participate which includes:

1. MAP 811 Non-Credentialed (Provider Application)(Revision 07/07);
2. MAP 811 Addendum E (Direct Deposit form) (Revision 04/08) and
3. ADO (Annual Disclosure Ownership Form)(Revision 08/06)

Copies of the MAP 811, MAP 811 Addendum E, and the ADO shall be submitted to:

Provider Enrollment
P.O Box 2110
Frankfort, KY 40602

Providers may also visit the Provider Enrollment website at https://kentucky.fhsc.com/kmaa/providers/enrollInfo.asp.

A home health agency participating in the Model Waiver II program shall meet the applicable certification requirements for providing home and community based waiver services in accordance with 907 KAR 1:671, 907 KAR 1:672, 907 KAR 1;675 and 907 KAR 1:030.

Services shall be furnished by the participating Model Waiver provider or by others under contractual arrangement with the Model Waiver provider either directly or through contractual arrangement. The Model Waiver provider shall

have responsibility for monitoring the service provision and ensuring that quality services are provided. Recipients shall not be enrolled for services which the agency cannot provide as ordered by the physician. Arrangements made by a Model Waiver provider with others to provide services shall be in writing and shall stipulate that receipt of payment by the Model Waiver provider for the service (whether in its own right or as an agent) discharges the liability of the recipient or the Medicaid Program to make any additional payment for service.

The nursing services provided by the Model Waiver provider shall be provided by Registered Nurses (RN) or Licensed Practical Nurses (LPN) who are licensed by the state of Kentucky. The respiratory therapy (RT) services provided by the Model Waiver provider shall be by respiratory therapists who are certified or registered by the National Board for Respiratory Care and who meet all applicable Federal and State requirements.

C. Record Requirements

The Model Waiver provider shall be required to maintain for each recipient a clinical record which covers the services provided both directly and those provided through contractual arrangements with other agencies; and which contains pertinent past and current medical, nursing, social, and other information including the comprehensive assessment and the plan of care.

The provider shall furnish any information to the Department for Medicaid Services (DMS) as may be requested by the Program.

All participating providers and their contractors and sub-contractors shall be required to make available upon request of CHFS, DMS, and the Comptroller General to examine such records and documents necessary to ascertain information pertinent to the determination of the proper amount of payments due and evaluate the provision of Model Waiver services. These records shall be kept by the provider and shall include:

1. Matters of agency ownership, organizations, and operation;
2. Fiscal, medical, and other record-keeping systems;
3. Federal income tax returns and status;
4. Asset acquisition, lease, sale or other action involving assets;
5. Franchise or management arrangements including costs of parent or “home office” operations;
6. Recipient service charge schedules;
7. All matters pertaining to costs of operation;
8. Amounts of income received by source and purpose; and
9. The flow of funds and working capital.

Medical records shall be maintained for a minimum of six (6) years per the Health Insurance and Portability Act (HIPAA) of 1996 and for such additional time as may be necessary in the event of an unresolved audit or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to DMS upon request and made available for inspection and copying by DMS personnel or its representative.

Medical records shall substantiate the services billed to Medicaid by the home health agency. The medical records shall be accurate and appropriate. All records shall be signed and dated.

The provider may be asked to provide additional information as necessary to assist Medicaid and the Department of Health and Human Services in evaluating this waiver.

D. Recipient/Provider Review

DMS has the responsibility for review of the MWII program with the recipient and the provider. The review will be an onsite review at the provider's actual location and will include a review of the individual recipient and a sample of the total Model Waiver II cases. Sample cases will be reviewed annually. The review shall be conducted by a registered nurse.

Included in the review shall be:

1. Review of medical records to assure that they are accurate and complete;
2. Review of the plans of care and services provided to assure that the services are provided as ordered by the recipient's physician, are signed by the physician within twenty-one (21) days of the development of the plan of care and/or received verbal orders, and are medically necessary;
3. Review of the documentation of the services provided to assure they have prior authorization;
4. Review of a sample of the services billed (taken from an ad hoc report of billed charges) compared against the services documented in the case record to assure that they were billed accurately;
5. Documentation from the Model Waiver II recipient during a random home visit to assure that the recipient is satisfied with the services provided and wishes to continue to receive the Model Waiver II services;
6. Documentation for compliance with MAP-350, Freedom of Choice; and
7. Documentation of incident reports which occurred during the review period.

NOTE: To avoid re-coupment of payments made by Medicaid to the MWII provider, the plan of care must be signed by the recipient's physician within the sixty (60) day plan of care certification period.

A summary report of the review will be prepared by DMS and the provider shall receive a report of the findings. If any deficiencies are found, the provider shall have 30 days to submit a corrective action plan. If re-coupment of Medicaid payments is required, appropriate action will be taken to begin the re-coupment process.

E. Termination of Provider Participation

Termination of a provider participating in the Medicaid Program shall be in accordance with the Department's administrative regulations which address the terms and conditions for provider termination and procedures for provider appeals.

F Out-of-State Providers

Out-of-State providers who possess a Kentucky Certificate of Need and are licensed to provide Home Health services to Medicaid Program recipients residing in Kentucky shall complete the same participation agreement forms required for in-state providers. An out-of-state provider not licensed to provide Home Health services in Kentucky shall not participate in the Model Waiver program.

G. Change of Ownership

The Model Waiver Program provider shall complete new participation agreement forms whenever the agency has had a change of ownership. The information and forms necessary to complete the application to participate in the Medicaid Program shall be:

1. MAP 811 Non-Credentialed (Provider Application)(Revision 07/07);
2. MAP 811 Addendum E (Direct Deposit form)(Revision 04/08) and
3. ADO (Annual Disclosure Ownership Form) (Revision 08/06).

These forms shall be submitted along with a cover letter stating that this represents a change of ownership, giving the old agency name, the name of the new agency and the effective date of the change the same as a new application. (**See Section IV – B**)

H. Withdrawal of Participation

If a provider withdraws from participation in Medicaid, written notice shall be given to the Department at least thirty (30) days prior to the effective date of withdrawal. Payment shall not be made for services or items provided to recipients on or after the effective date of withdrawal.

I. Disclosure of Information (942 CFR 405, 420, 413 and 455)

There are requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act). The Federal regulations implement sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142).

The portions applicable to Medicaid are outlined below:

1. The Department for Health and Human Services (HHS) or DMS may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents, or managing employees has been convicted of criminal offenses involving any of the programs under Title XVIII, XIX, or XX.
2. HHS or DMS may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program related criminal offense at the time the agreement was entered into.
3. HHS shall have access to all Medicaid provider records.
4. Providers shall be required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these new requirements, the Federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and note information which may be requested concerning business transactions.

J. Patient Consent Forms

The Office of Inspector General (OIG) and the Department personnel shall not be required to have completed patient consent forms prior to or upon reviewing or investigating patient records or provider records which relate to the Kentucky Medicaid Program.

K. Appeal Process for Refund Requests

The Appeal Process for Refund Requests shall be in accordance with 907 KAR 1:671, Conditions of Medicaid Provider Participation; Enrollment, Documentation of Services, Disclosure, Claims Processing, Withholding Overpayment, Appeals Process, and Sanctions.

SECTION V –PROGRAM COVERAGE

V. PROGRAM SERVICES

Model Waiver Program services provided by Title XIX participating Model Waiver Program providers shall be payable by the Medicaid Program, when provided to Medicaid recipients who have been determined by the QIO to meet the level of care for nursing facility (NF) services, have chosen to receive Model Waiver services, and have been prior authorized by the Department for Medicaid Services (DMS) or their authorized representative to receive Model Waiver Program services. The recipient's physician shall order the Model Waiver services.

A. Entry into Model Waiver Program

A Medicaid recipient may be referred for Model Waiver services from a hospital or the community. Additionally, a recipient may be referred for Model Waiver services from a NF. Recipients who are considering placement in a NF or who are in need of additional services in order to remain at home would need to be referred to the Model Waiver provider. The Model Waiver provider shall explain the Model Waiver program. If the recipient is interested in Waiver services, the MAP 350 form shall be completed indicating that he is interested in the Model Waiver Program. Information shall be gathered about the patient as required by the QIO for use in the level of care determination.

The physician shall order Model Waiver services.

B. Level of Care Determination and Plan of Care

The QIO shall perform a level of care determination for all Medicaid recipients who request the services of a NF, as well as recipients who are faced with possible NF placement and wish to be considered for the Model Waiver services alternative.

The level of care determination will be made in accordance with the requirements as defined in Federal Regulations, 42 CFR 440.40 and 440.150 respectively. The level of care determination shall be made at least every six (6) months.

The Model Waiver provider shall contact the QIO to provide the information necessary to perform the level of care determination. The level of care certification form shall be completed by the QIO based upon the information provided. A copy of the completed form indicating the level of care determination shall be forwarded by the QIO to the Model Waiver provider. The

individual contacting the QIO shall be knowledgeable about the patient's condition and able to answer questions which may be asked.

The following resources along with the physician's orders for services may be utilized to provide the QIO with the information necessary for the level of care determination:

a. A recent hospital discharge summary;
b. A recent physician history and physical examination report;
c. A home health agency assessment; or
d. Any other information as requested.

Data for the level of care determination shall be telephoned to the QIO for review. The QIO shall advise the Model Waiver provider, in writing, of the level of care determination within five (5) working days by means of the Confirmation Notice or Adverse Action form.

Upon notification that the recipient's care needs are within the scope of NF benefits, the Model Waiver provider shall complete the comprehensive assessment process, including the development of the plan of care, and the estimation of Title XIX cost, etc.

The provider sends a packet of information at certification or recertification to the QIO for review of the recipient's condition to determine if all criteria for eligibility for the Model Waiver II program are met as well as authorizing services. The specific prior authorization procedures are to ensure that:

1. Level of care criteria and Model Waiver II eligibility requirements are met;
2. Model Waiver II services are defined in the approved plan of care;
3. Services are medically necessary;
4. Services prevent institutionalization and allow the individual to reside in the community;
5. Services are adequate to meet the individual's needs;
6. Cost of services shall not reasonably be expected to exceed the cost of the appropriate level of institutional care on an aggregate; and
7. Assurance that the individual has been given freedom of choice to receive home and community based services rather than nursing facility services.

The Model Waiver services under the program shall be provided in accordance with a properly developed plan of care. The individual plan of care shall be developed in accordance with the physician's orders by a registered nurse on the staff of a participating home health agency. The plan of care shall specify medical and other services to be furnished, and the frequency and type of

provider who shall provide them. It shall contain provisions for re-evaluation at least every sixty (60) days. A copy of each plan of care shall be submitted to DMS or their authorized representative as designated by DMS. The every sixty (60) day re-evaluation of the plan of care does not include a level of care determination by the QIO. The Home Health Agency shall request a level of care determination from the QIO every six (6) months.

C. Denials and Appeal Procedures

The Model Waiver provider, Kentucky Medicaid recipient, and DMS will receive notification from the QIO of the denial for NF Level of Care in accordance with regulation 907 KAR 1:022.

Appeal Process for Reconsideration:

If the recipient or his legal representative disagrees with the adverse determination, the recipient shall have the right to appeal the decision by requesting a reconsideration of the adverse action in accordance with 904 KAR 2:055, Section 16.

D. Prior Authorization

DMS shall prior authorize Model Waiver services to ensure that patient status is met, Model Waiver services shall be adequate for the needs of the recipient, and the costs shall not reasonably be expected to exceed the cost of institutional care. Consideration shall be given to each individual's home situation, caregiver support available, type and amount of service requested, and that NF placement would be recommended without Model Waiver services.

The Prior Authorization form (MAP 109-MWII) is to be completed requesting the specific service & costs and submitted to:

SHPS
Attention: Model Waiver
9200 Shelbyville Road
Louisville, KY 40222

The Model Waiver II provider may copy and download an electronic version of this form from the DMS website, http://chfs.ky.gov/dms/mwii. The link to the MAP -109 will be on the right hand side of the page. Once completed, this form may be faxed to the QIO for processing at (800) 807-7840, (800) 807-8843, or (502) 429-5233. Any MAP 109-MWII that has been altered from the original

format of the current version as found on the above website will not be processed.

Included with the above must be:

a. Accurately completed Assessment/Reassessment form (MAP 351A revised 06/15/02).
b. MAP 109-MWII (revised 4/04) Plan of Care/Prior Authorization for Model Waiver II Services, including the specific type of services anticipated frequency and duration of services, signed and dated by the physician for Model Waiver services.
c. The Level of Care Certification form issued by the QIO (Confirmation Notice).
d. Certification Form (MAP 350) revised January 2000, to certify desire to receive HCBS Waiver Service (Model Waiver).

For individuals who are not Medicaid recipients, the DCBS office, and the Model Waiver provider will receive a letter stating the individual is approved for waiver services and that the individual shall contact the DCBS office to make application for Medicaid.

For individuals who are Medicaid recipients, the Model Waiver provider will receive a letter from the authorized billing agent indicating services which are prior authorized.

E. Continuation of Services:

The Model Waiver II provider shall recertify the recipient for the Model Waiver II program. The provider shall evaluate the recipient's need for continuation of services and obtain the physician's plan of care. Prior authorization of the individual for the Model Waiver II program shall be completed at least every two months, not to exceed sixty (60) days. A Model Waiver II provider may request a Model Waiver II recipient's recertification up to twenty-one (21) days prior to the end of the current certification period or up to fourteen (14) days after the last day of the current certification period. Any prior authorization (PA) request packet received after the fourteen (14) day timeframe will have a PA start date reflective of the date the completed recertification packet is received by the QIO.

The recipient must be recertified for level of care at least every six (6) months. This process is the same as identified for the initial assessment.

F. Denial

The recipient and the Model Waiver provider initiating the application shall receive notification when a recipient is denied for the Model Waiver program.

The recipient or his legal representative shall have up to thirty (30) days from the date of receipt of the adverse notice to make a written request for a hearing. For the individual currently in Medicaid payment status, if a hearing is requested within ten (10) days of receipt of the adverse notice, Medicaid benefits shall not be terminated before the hearing is held.

The request shall be submitted to"

Cabinet for Health and Family Services (CHFS)
Department for Community Based Services
Administrative Review
275 East Main Street
Frankfort, Kentucky 40621.

G. Terminations

DMS shall be notified by the Model Waiver II provider whenever a recipient has been terminated from the Model Waiver Program. The provider shall submit a MAP 24 letter to DCBS:

Cabinet for Health and Family Services
Department for Community Based Services
275 East Main Street
Frankfort, KY 40621

And

Department for Community Based Services
Cabinet for Health and Family Services
(Office in the county of residence of the recipient)

H. Application for Medicaid Benefits

The medically indigent individual who is not currently a Medicaid recipient but has been approved for Model Waiver services may apply for Medicaid benefits at the DCBS office in the individual's county of residence. An interested party may apply on behalf of the individual. Individuals applying for Medicaid who are

income ineligible have the option of placing their excess monthly income into an irrevocable Qualified Income Trust (QIT) per 907 KAR 1:650 to become categorically needy for Medicaid.

I. Covered Services

The following services shall be covered services under the Model Waiver program, when provided to a Medicaid program recipient who is eligible for services under the waiver. Coverage shall not be made under the waiver for any service if the recipient is not eligible for Medicaid, or is determined not to meet the Level of Care criteria for NF service.

1. Private Duty Nursing Services

   Private duty nursing services shall be reimbursable for up to sixteen (16) hours per day, or according to the physician's order if less than sixteen (16) hours per day for the Model Waiver II program. These services shall be provided by a registered nurse or licensed practical nurse, licensed by the Kentucky Board of Nursing. Private duty nursing services shall be included in the individual's plan of care which shall be developed in accordance with the physician's orders.

2. Respiratory Therapy Services

   Respiratory therapy services shall be reimbursable under the Model Waiver when ordered by the physician and provided by a qualified respiratory therapist. A qualified respiratory therapist shall be a respiratory therapist who is certified or registered by the National Board for Respiratory Care and meets all applicable Federal and State requirements.

   Respiratory therapy shall be reimbursable only through the Model Waiver II program.

   The Revenue codes for the Model Waiver II program shall be:

REVENUE CODE	SERVICE	UNIT
552	Registered Nurse	1 hour
559	Licensed Practical Nurse	1 hour
410	Respiratory Therapy	1 hour

VI. REIMBURSEMENT

A. General Information

DMS shall reimburse participating providers of Model Waiver Services for services provided to eligible Medicaid recipients who meet patient status criteria for NF services, and who are prior authorized for Model Waiver services.

Reimbursement for Model Waiver II services shall be a fee for service reimbursement with the allowed amount to be determined by DMS. The allowed amount shall not exceed usual and customary charges of the provider.

B. Units of Service

A unit of service for nursing (Registered Nurse or Licensed Practical Nurse) and for Respiratory Therapy shall be defined as one (1) unit equaling one (1) hour. For Model Waiver II the units of service for nursing or respiratory therapy shall not exceed sixteen (16) units (hours) of service per day.

C. Rates

RN = $31.98 per unit
LPN = $29.10 per unit
RT = $27.42 per unit

1 unit = 1 hour (minutes are not to be rounded to next hour).

D. Audits

Audits shall be performed as necessary to ensure that final payments to providers are made in accordance with these payment provisions.

E. Claim Submission and Forms

The UB-04 shall be used to bill for covered Model Waiver Services. For information on completion of the UB-04 claim form and completion of the other forms used by the Model Waiver Program, visit the Provider Billing Instructions page at http://www.kymmis.com/kymmis/Provider%20Relations/billingInst.aspx.

You may also obtain the UB-04 billing forms from the Kentucky Hospital Association; P.O. Box 24163; Louisville, KY 40224 Telephone: (502) 426-6220

Once completed, the form may be faxed to the fiscal agent for processing at (800) 807-7840, (800) 807-8843 or (502) 429-5233. Any forms altered from the original format of the current version as found on the above website will not be processed.

Effective May 23rd 2008, providers must start using their National Provider Identifier number (NPI) and taxonomy, if applicable, for submitting claims. It is very important to enter the correct NPI/taxonomy, if applicable, on claim forms to ensure correct provider payment. For more information on billing with your NPI number, refer to the Provider Billing Instructions at http://www.kymmis.com/kymmis/Provider%20Relations/billingInst.aspx.

All provider records, including remittance statements, are maintained by the system by provider ID. An incorrect or missing number can result in payment to another provider or denial of the claim.

SECTION VII- REIMURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

VII. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the Medicaid recipient. At the same time the provider obtains Medicaid billing information from the recipient, an obligation exists for the provider to investigate and report the existence of other insurance or liability if applicable. The provider's cooperation shall enable the Kentucky Medicaid Program to function efficiently.

B. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program all participating providers shall submit billings for medical services to a third party when such provider has prior knowledge that the third party may be liable for payment of the service.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- If the recipient is a minor, ask about insurance the mother, father, or guardian may carry on the recipient;
- In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- For people over age sixty-five (65) or disabled, seek a Medicare HIC number;
- Ask if the recipient has health insurance (e.g., a Medicare Supplement policy, cancer, accident, or indemnity policy, group health or individual insurance, etc.).

VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. General Information

The Medicare Program shall be billed for services which would be covered by the Medicare Program. The Medicaid program shall not be billed for services which could have been covered by the Medicare Program. It is the responsibility of the home health agency to keep abreast of current Medicare coverage guidelines and bill according to the guidelines.

(1) Deductible and Coinsurance
   (a) The Medicaid Program will make payment to the home health agency for the Medicare deductible and coinsurance due for the services provided to eligible recipients by the home health agency.
   (b) Services, including therapies, provided in a nursing facility are excluded from coverage. This will be edited through post-payment review.

(2) Billing Instructions
   (a) All necessary billing should be completed with the Medicare Intermediary before any billing is submitted to EDS.
   (b) Upon receipt of Medicare's Remittance Advice, the home health agency may bill EDS for the deductible and coinsurance amount due for a Medicaid eligible recipient. All Medicare deductible and coinsurance claims must be billed on a UB-04 claim form with a copy of the Medicare Remittance Advice attached.
   (c) There may be several recipients listed on the Medicare Remittance Advice. It is necessary to make a copy of the Medicare Remittance Advice and attach it to the completed UB-04 claim form submitted to EDS. The recipient information on the Medicare Remittance Advice for which the Medicare billing statement is applicable MUST be underlined in RED.

B. Recipients who are eligible for Medicare but the services have been rejected by the Medicare Intermediary

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Medicare and the agency will be billing the Medicaid Program for services or medical supplies provided.

The condition code field on the UB-04 shall be marked with a "Y1" to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every twelve (12) months. A copy of the Medicare denial must be available in the recipient's record.

C. Reimbursement for a recipient who is eligible for Medicare when it has been determined by Utilization Review that the services would not be covered under the Medicare Program.

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Utilization Review and the agency will be billing the Medicaid Program for services provided. The condition code field on the UB-04 must be marked with a "Y1" to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every twelve (12) months. A copy of the Medicare denial must be available in the recipient's record.

It is emphasized again that the Medicare Program has the primary liability to cover those services which meet the Medicare Program guidelines. The Medicaid Program has the secondary liability in relation to Medicare. **Medicaid is always the payer of last resort.**